In the United States Court of Federal Claims
OFFICE OF SPECIAL MASTERS
No. 04-0437V
Filed: February 7, 2013
(Not to be Published)

LINDA R. ARMSTRONG, individually and as next friend of Joshua Earl Armstrong a minor,	*	
Petitioner,	*	Autism; Statute of Limitations; Untimely Filed.
v.	*	
SECRETARY OF HEALTH AND HUMAN SERVICES,	*	
Respondent.	*	

DECISION[1]

On March 17, 2004, Linda Armstrong ("Petitioner"), on behalf of her son, Joshua Armstrong, filed a claim for compensation pursuant to the National Vaccine Injury Compensation Program ("Vaccine Program" or "the Program").[2] In her petition, she alleged that Joshua received a series of mercury-containing vaccines and subsequently demonstrated developmental problems.[3] (Petition ("Pet") at 1.)

[1] Because this decision contains a reasoned explanation for the action in this case, I intend to post this decision on the United States Court of Federal Claims' website, in accordance with the E-Government Act of 2002, Pub. L. No. 107-347, § 205, 116 Stat. 2899, 2913 (codified as amended at 44 U.S.C. § 3501 (2006)). In accordance with Vaccine Rule 18(b), a party has 14 days to identify and move to delete medical or other information that satisfies the criteria in 42 U.S.C. § 300aa-12(d)(4)(B). Further, consistent with the rule requirement, a motion for redaction must include a proposed redacted decision. If, upon review, I agree that the identified material fits within the requirements of that provision, I will delete such material from public access.

[2] The National Vaccine Injury Compensation Program comprises Part 2 of the National Childhood Vaccine Injury Act of 1986, Pub. L. No. 99-660, 100 Stat. 3755, codified as amended, 42 U.S.C.A. §§ 300aa-10 et. seq. (2006). Hereafter, individual section references will be to 42 U.S.C. § 300aa of the Act.

[3] Petitioner also adopted "by reference the MASTER AUTISM PETITION FOR VACCINE COMPENSATION." Petition at 1. A petitioner utilizing that Master Autism Petition alleges that

Petitioner has the burden to demonstrate that her case was properly and timely filed under the Vaccine Act's statute of limitations. § 16(a)(2). Based on my analysis of the evidence, Petitioner has not met her burden, and thus **this case is dismissed as untimely filed.**

I

BACKGROUND

This case concerning Joshua Armstrong is one of more than 5,000 cases filed under the Program in which it has been alleged that a child's disorder known as "autism," or a similar disorder, was caused by one or more vaccinations. A brief summary of one aspect of that history is relevant to this Decision.

A. The Omnibus Autism Proceeding

In anticipation of dealing with such a large group of cases involving a common factual issue--*i.e.*, whether vaccinations can cause autism--the Office of Special Masters ("OSM") devised special procedures. On July 3, 2002, the Chief Special Master, acting on behalf of the OSM, issued a document entitled the Autism General Order # 1,[4] which set up a proceeding known as the "Omnibus Autism Proceeding" (OAP). In the OAP, a group of counsel selected from attorneys representing petitioners in the autism cases, known as the Petitioners' Steering Committee ("PSC"), was charged with obtaining and presenting evidence concerning the general issue of whether those vaccines can cause autism, and, if so, in what circumstances. The

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> [a]s a direct result of one or more vaccinations covered under the National Vaccine Injury Compensation Program, the vaccinee in question has developed a neurodevelopmental disorder, consisting of an Autism Spectrum Disorder or a similar disorder. This disorder was caused by a measles-mumps-rubella (MMR) vaccination; by the "thimerosal" ingredient in certain Diphtheria-Tetanus-Pertussis (DTP), Diphtheria-Tetanus-acellular Pertussis (DTaP), Hepatitis B, and Hemophilus Influenza Type B (HIB) vaccinations; or by some combination of the two.

Autism General Order #1, 2002 WL 31696785 at *2 (Fed. Cl. Spec. Mstr. July 3, 2002).

[4] The *Autism General Order # 1* is published at 2002 WL 31696785, 2002 U.S. Claims LEXIS 365 (Fed.Cl.Spec.Mstr. July 3, 2002). I also note that the documents filed in the Omnibus Autism Proceeding are contained in a special file kept by the Clerk of this court, known as the "Autism Master File." An electronic version of that File is maintained on this court's website. This electronic version contains a "docket sheet" listing all of the items in the File, and also contains the complete text of most of the items in the File, with the exception of a few documents that are withheld from the website due to copyright considerations or due to § 300aa-12(d)(4)(A). To access this electronic version of the Autism Master File, visit this court's website at www.uscfc.uscourts.gov. Select the "Vaccine Info" page, then the "Autism Proceeding" page.

evidence obtained in that general inquiry was to be applied to the individual cases. (Autism General Order # 1, 2002 WL 31696785, at *3, 2002 U.S. Claims LEXIS 365, at *8.)

Ultimately, the PSC elected to present two different theories concerning the causation of autism. The first theory alleged that the *measles* portion of the MMR vaccine can cause autism, in situations in which it was alleged that thimerosal-containing vaccines previously weakened an infant's immune system. That theory was presented in three separate Program "test cases," during several weeks of trial in 2007. The second theory alleged that the mercury contained in the thimerosal-containing vaccines can *directly affect* an infant's brain, thereby substantially contributing to the development of autism. The second theory was presented in three additional "test cases" during several weeks of trial in 2008.

On February 12, 2009, decisions were issued concerning the three "test cases" pertaining to the PSC's *first* theory. In each of those three decisions, the petitioners' causation theories were rejected. I issued the decision in *Cedillo v. HHS*, No. 98-916V, 2009 WL 331968 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Patricia Campbell-Smith issued the decision in *Hazlehurst v. HHS*, No. 03-654V, 2009 WL 332306 (Fed. Cl. Spec. Mstr. Feb. 12, 2009). Special Master Denise Vowell issued the decision in *Snyder v. HHS*, No. 01-162V, 2009 WL 332044 (Fed. Cl. Spec. Mstr. Feb. 12, 2009).

Those three decisions were later each affirmed in three different rulings, by three different judges of the U.S. Court of Federal Claims. *Hazlehurst v. HHS*, 88 Fed. Cl. 473 (2009); *Snyder v. Secretary of HHS*, 88 Fed. Cl. 706 (2009); *Cedillo v. HHS*, 89 Fed. Cl. 158 (2009). Two of those three rulings were then appealed to the U.S. Court of Appeals for the Federal Circuit, again resulting in affirmances of the decisions denying the petitioners' claims. *Hazlehurst v. HHS*, 604 F. 3d 1343 (Fed. Cir. 2010); *Cedillo v. HHS*, 617 F. 3d 1328 (Fed. Cir. 2010).

On March 12, 2010, the same three special masters issued decisions concerning three separate "test cases" pertaining to the petitioners PSC's *second* causation theory. Again, the petitioners' causation theories were rejected in all three cases. *King v. HHS*, No. 03-584V, 2010 WL 892296 (Fed.Cl.Spec.Mstr. Mar. 12, 2010); *Mead v HHS*, No. 03-215V, 2010 WL 892248 (Fed.Cl.Spec.Mstr. Mar. 12, 2010); *Dwyer v. HHS*, No. 03-1202V, 2010 WL 892250 (Fed.Cl.Spec.Mstr. Mar.12, 2010). None of the petitioners elected to seek review any of those three decisions.

II

PROCEDURAL HISTORY

The petition filed in this case, on March 17, 2004, included only Joshua's birth certificate and vaccination record. Thus, this petition was filed without all of the medical records required by Section 11(c) (2) of the Vaccine Act or Rule 2 of the Rules of the United States Court of Federal Claims, Appendix B.

Over the next five years, Petitioner filed additional medical records. On June 15, 2009, I issued an order directing the Secretary of Health and Human Services ("Respondent") to file a statement regarding the appropriateness of further processing this claim in the Omnibus Autism Proceeding ("OAP"). (Order, ECF No. 10.) On September 4, 2009, Petitioner filed medical records containing Exhibits one through six. (Notice, ECF No. 12.) On September 8, 2009, Petitioner filed a Statement of Compliance indicating that she had filed all records necessary to comply with the initial required medical records production. (Statement, ECF No. 13.)

On October 16, 2009, Respondent filed a Motion to Dismiss ("Resp. Mot."), arguing that Petitioner's claim was untimely filed under the Vaccine Act's statute of limitations. (Resp. Motion at 1; *see also*§ 16(a)(2) for the requirements of the Vaccine Act's statute of limitations.) Petitioner, at that time represented by counsel, filed a response on November 16, 2009, arguing that such untimely filing should be excused pursuant to the doctrine of "equitable tolling." (Pet. Response to Resp. Motion to Dismiss, at 2-5.)

On July 9, 2012, April 20, 2012, and August 28, 2012, I ordered Petitioner to show cause why this claim should not be dismissed as untimely filed, by filing supporting documents for her claim. (Orders, ECF Nos. 19, 20, 22.)

On September 21, 2012, Petitioner filed her response to my Order of August 28, 2012. (ECF No. 23.) In that response, Petitioner stated that she needed more time in submitting documentation regarding Joshua's autism claim. (*Id.*)

On September 26, 2012, I issued an order granting Petitioner an enlargement of time, until November 26, 2012, to file the required medical records to support her claim. (Order, ECF No. 24.) Petitioner, however, has not filed anything further with this Court.

III

FACTUAL HISTORY

Joshua was born on December 21, 1996. (Pet. at 1.) Joshua received routinely administered childhood vaccinations between December 22, 1996, and February 20, 2001. (Pet. at 3.)

On July 12, 1999, medical records from D.C. General Hospital indicate that Joshua presented for an examination due to "concerns of his not talking." (Pet. Ex. 1 at 5.) At this visit, Joshua was noted to "mouth objects, plays with his fingers, is variable in showing interest toward people, and rocks his body when he is around strangers." (*Id.* at 6.) Joshua's pediatrician, Dr. McMorris, M.D., noted her impression of "[d]elayed speech and language and delayed/ impaired interactive skills." (*Id.* at 8.)

At the age of two years, following a Genetics Consultation on October 4, 1999, Cynthia J. Tifft, M.D., Ph.D., conducted a thorough evaluation and ruled out any chromosomal

abnormalities, including a Fragile X screen, which was normal. (Pet. Ex. 3 at 32.) Dr. Tifft concluded that:

> Joshua is a now 2 9/12-year old with global developmental delays and some autistic-like features including eye aversion, echolalia, and self-stimulatory behaviors. My differential diagnosis includes pervasive developmental delay versus the fragile X syndrome versus possible Coffin-Lowry syndrome.

(Pet. Ex. 1 at 25.) Dr. Tifft's recommendations were that Joshua should begin early intervention services at D.C. General Hospital to involve speech, physical, and occupational therapy. (*Id.*)

At the age of three years, it is noted in Joshua's medical history that Joshua was seen by Dr. Mark Batshaw at Children's National Medical Center, where Dr. Batshaw indicated that Joshua had deficits consistent with a Pervasive Developmental Disorder. (Pet. Ex. 3 at 32.)

In July of 2001, Joshua was referred for a speech and language evaluation by the Complex Developmental Disorder Team of the Spring Valley Regional Outpatient Center of Children's National Medical Center. (Pet. Ex. 1 at 27.) It was noted that Joshua's speech and language skills had not been tested previous to "this assessment," and that he has a history of middle ear infections. (*Id.*) The examiner, Joy Starnes, M.S., CCC-SLP, noted her impression that Joshua was a child "with significantly impaired language skills in the presence of age-appropriate speech skills. Pragmatic (social) language skills were also significantly impaired." (*Id.*)

On August 21, 2001, Joshua was referred to the Pervasive Developmental Disorders Clinic for a developmental evaluation orchestrated by Dr. Patricia Gates. (Pet. Ex. 3 at 1-12.) Joshua received a definitive diagnosis of autism on this date. (*Id.*)

IV

DIAGNOSTIC CRITERIA FOR AUTISM SPECTRUM DISORDERS

No evidence concerning the diagnostic criteria for autism spectrum disorders was filed by the parties in this case. Accordingly, I have relied upon the information set forth below in this Section IV of this Decision, which is drawn from OAP test case testimony[5] provided by three

[5] All of the evidence filed in the OAP test cases is available to any petitioner in the OAP, as well as to respondent. However, I note that there did not appear to be any material disputes in the OAP test cases about what constituted the early symptoms of autism or other ASD's.

Because the omnibus test case decisions are not binding on the other omnibus participants, the primary advantage to both parties in conducting test case hearings is the creation of a body of evidence that can be considered in other cases. *Snyder v. HHS*, No. 01-162V, 2009 WL 332044, at *2-3 (Fed. Cl. Spec. Mstr. Feb. 12, 2009); *Dwyer v. HHS*, No. 02-1202V, 2010 WL 892250, at *2 (Fed. Cl. Spec. Mstr. Mar. 12, 2010).

pediatric neurologists with considerable experience in diagnosing ASDs. I further note that the information in this section was first compiled and published by my colleague, Special Master Vowell, in *White v. HHS*, 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011).

"The terms 'autism' and 'autism spectrum disorder' have been used to describe a set of developmental disorders characterized by impairments in social interaction, impairments in verbal and non-verbal communication, and stereotypical restricted or repetitive patterns of behavior and interests." (*Cedillo*, 2009 WL 331968, at *7 (Fed. Cl. Spec. Mstr. Feb. 12, 2009) (an OAP "test case.")) The specific diagnostic criteria for ASD are found in the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 4th ed. text revision 2000 ("DSM-IV-TR"), the manual used in the United States to diagnose dysfunctions of the brain. (*See* testimony in *Cedillo* ("*Cedillo* Tr.") at 1278A.[6]) The manual identifies the behavioral symptoms recognized by the medical profession at large as symptoms of ASD.[7] The DSM-IV-TR contains specific diagnostic criteria for autistic disorder, Asperger's disorder, and pervasive developmental disorder-not otherwise specified (most frequently referred to as ("PDD-NOS")). It is not uncommon for parents and even health care providers to use these terms in non-specific ways, such as referring to a child as having an "autism diagnosis," even though the specific diagnosis is PDD-NOS. Of note, a child's diagnosis within the autism spectrum may change from autistic disorder to PDD-NOS (or vice versa) over time.

A. Diagnosing Autism Spectrum Disorders

The behavioral differences in autism spectrum disorders encompass not only delays in development, but also qualitative abnormalities in development. (*Cedillo* Tr. at 1264A, 1589-91.) There can be wide variability in children with the same diagnosis. One child might lack language at all, while another with a large vocabulary might display the inability to engage in a non-scripted conversation. (*Cedillo* Tr. at 1602A-1604.) However, both would have an impairment in the communication domain.

Testing for the presence of an ASD involves the use of standardized lists of questions about behavior directed to caregivers and parents, as well as observations of behaviors in standardized settings by trained observers. (*Cedillo* Tr. at 1272A-74A.) One behavioral symptom alone, such as hand-flapping, would not be diagnostic of an ASD, but if present, it would be a symptom that would be part of the diagnostic picture. As one expert explained, in diagnosing an ASD, "we try to observe symptoms, and when we have observed enough

[6] Transcripts from the OAP test cases, including *Cedillo* and *King*, may be accessed at http://www.uscfc.uscourts.gov/omnibus-autism-proceeding (last checked on June 19, 2012).

[7] Pervasive developmental disorder ("PPD") is the umbrella term used for all autism spectrum disorders in the DSM-IV-TR at 69. I use the term ASD rather than PDD because of the possible confusion between "PDD" (the umbrella term referring to the general diagnostic category) and "PDD-NOS," which is a specific diagnosis within the general diagnostic category of PDD or ASD. *See Dwyer*, 2010 WL 892250, at *1 n.4 & *29 n.108.

symptoms, then we see if the child meets these criteria." (*Cedillo* Tr. at 1278A-79; *see also* testimony in the *King* OAP test case ("*King* Tr.") at 3253-54 (describing diagnostic instruments and their use in clinical settings); *King*, 2010 WL 892296.)

Typically in children with autism spectrum disorders, the symptoms have been present for weeks or months before parents report them to health care providers. (*Cedillo* Tr. at 1283.) The most common age at which parents recognize developmental problems, usually problems in communication or the lack of social reciprocity, is at 18-24 months of age. (*King* Tr. at 3259-60.) The development of symptoms of an ASD occurs very gradually, and it is not uncommon for the parents to be unable to date the onset very precisely. (*Cedillo* Tr. at 1285A-1286A.)

1. Autistic Disorder (Autism)

A diagnosis of autistic disorder requires a minimum of six findings from a list of impairments divided into three domains of impaired function: (1) social interaction; (2) communication; and (3) restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. At least two findings related to social interaction and at least one each in the other two domains are required for diagnosis. To meet the diagnostic criteria for autism, the child must have symptoms consistent with six of the twelve listed types of behavioral impairments. Furthermore, the abnormalities in development must have occurred before the age of three. (*Cedillo* Tr. at 1264A, 1279, 1618; *King* Tr. at 3250.) Although the majority of children with autism have developmental delays, many are of normal intelligence. (*Cedillo* Tr. at 1276; *King* Tr. at 3256.) In testimony in the *Cedillo* OAP test case, one expert described the three domains as the "core features" of a diagnosis on the autism spectrum. (*Cedillo* Tr. at 1589-92.) Children with autism are most symptomatic in the second and third years of life. (*Cedillo* Tr. at 1618.)

2. Pervasive Developmental Disorder-Not Otherwise Specified

The DSM-IV-TR defines PDD-NOS as "a severe and pervasive impairment in the development of reciprocal social interaction," coupled with impairment in either communication skills or the presence of stereotyped behaviors or interests. (DSM-IV-TR at 84.) The diagnosis is made when the criteria for other autism spectrum disorders, or other psychiatric disorders, such as schizophrenia, are not met. (*Id*.) It includes what has been called "atypical autism," which includes conditions that present like autistic disorder, but with onset after age three, or which fail to meet the specific diagnostic criteria in one or more of the domains of functioning. (*Id*.) As was noted in the *Dwyer* OAP test case, this is the most prevalent of the disorders on the autism spectrum. (*Dwyer*, 2010 WL 892250, at *30.)

3. Asperger's Disorder

Asperger's syndrome is a form of high-functioning autism. It presents with significant abnormalities in social interaction and with restricted, repetitive, and stereotyped patterns of behavior, interests, and activities. (*See* DSM-IV-TR at 84.)

B. The Domains of Impairment and Specific Behavioral Symptoms

1. Social Interaction Domain

This domain encompasses interactions with others. (*Cedillo* Tr. at 1264A.) There are four subgroups within this domain. (*Id.* at 1594.) The subgroups include: (1) a marked impairment in the use of nonverbal behavior, such as gestures, eye contact and body language; (2) the failure to develop appropriate peer relations; (3) marked impairment in empathy; and (4) the lack of social or emotional reciprocity. (*Id.* at 1594-96.) To be diagnosed with autism (autistic disorder), the patient must have behavioral symptoms from two of the four subgroups. (*Id.* at 1594.) For an Asperger's diagnosis, there must be two impairments in this domain as well. (DSM-IV-TR at 84.) Children who do not display "the full set of symptoms" are diagnosed with PDD-NOS. (*Cedillo* Tr. at 1275A.) Symptoms used to identify young children with impairments in the social interaction domain include lack of eye contact, deficits in social smiling, lack of response to their name, and the inability to respond to others. (*Cedillo* Tr. at 1269A-70A.)

One expert described the degrees of impairment in interactions with others as a continuum, with affected children ranging from socially unavailable to socially impaired. A child who is socially unavailable may exhibit such behaviors as failing to seek consolation after injury or purposeless wandering, or may simply appear isolated. (*Cedillo* Tr. at 1598.) A less impaired child might be socially remote, responding to an adult's efforts at social interaction, but not seeking to continue the contact. This child might roll a ball back and forth with an adult, but will not protest when the adult stops playing. (*Cedillo* Tr. at 1599.) Given a choice between playing with peers and playing by himself, a child with impairments in social interaction will play by himself. (*Id.*) Some children with ASD demonstrate socially inappropriate interactions, such as pushing other children in an effort to interact. (*Cedillo* Tr. at 1600.) A higher functioning child might attempt interaction, but does so as if reading from a script. As an example, Dr. Wiznitzer discussed a patient who, when asked where he lived, could not answer, but responded appropriately when Dr. Wiznitzer asked the child for his address. (*Id.* at 1601.)

2. Communication Domain

The communication domain involves both verbal and non-verbal communication, such as intonation and body language. (*Cedillo* Tr. at 1263, 1602A.) Language abnormalities in ASD encompass not only delays in language acquisition, but the lack of capacity to communicate with others. (*Id.* at 1267A.) Impaired communication abilities are one of the "most important and early recognized symptoms" of autism. (*Dwyer*, 2010 WL 892250 at *31.)

There are four criteria within the communication domain. (*Cedillo* Tr. at 1602A.) They include: (1) a delay in or lack of development in spoken language, without the use of signs or gestures to compensate; (2) problems in initiating or sustaining conversation; (3) stereotypic or repetitive use of language, including echolalia and repeating the script of a video or radio presentation, such as singing a commercial jingle; and (4) the lack of spontaneous imaginative or make-believe play. (*Cedillo* Tr. at 1602A-05.)

Language delay, limited babbling, lack of gestures, lack of pointing to communicate things other than basic wants and desires (lack of "protodeclarative" vs. "protoimperative" pointing), are all early symptoms used to diagnose impairments in the communication domain. (*Cedillo* Tr. at 1266A-68A.) One expert described the failure to share discoveries via language in autistic children as well. (*Cedillo* Tr. at 1606A.) Children with ASD who have more developed language skills may display difficulties in social communication outside their limited area of interest. (*Id*. at 1607.)

Within the communication domain, children with ASD have difficulties in joint attention, which one expert described as sharing an action or activity with another person or even an animal. They have problems with what he called metalinguistic skills, referring to the meaning behind the language used, which may be conveyed by tone, body language, humor, or sarcasm. Children with ASD may understand visual humor, illustrated by the cartoon of an anvil falling on the coyote's head, but lack the ability to understand a joke. (*Cedillo* Tr. at 1607-09.) They focus on the literal, rather than figurative, meaning of words: telling a child with ASD to "hop to it" may elicit hopping, rather than an increase in speed in completing a task. These children use language primarily for getting their needs met. (*Id*. at 1609.) A child with ASD might lead a parent to the cookie jar, but would not lead a parent to a caterpillar crawling along the sidewalk.

Children with ASD often have impairments in specific types of play. They may understand cause and effect play, but have difficulties in imitative or representational play. They can push a button to make a toy figure pop up, but have difficulty with holding a tea party, putting a stuffed animal to bed, or feeding a doll. (*Cedillo* Tr. at 1610-11.) They also have impairments in symbolic play, in which an object such as a stick represents another object, such as a magic wand or sword. (*Id*. at 1612.)

Speech and language delays are the symptoms most commonly reported by parents as a concern leading to a diagnosis of ASD. (*See Cedillo* Tr. at 1284 (one of first concerns noted by parents is the lack of language development); *King* Tr. at 3253 (problems in social and communication domains tend to be observed much earlier than stereotyped behaviors.))

A deficit in at least one of the subgroups in the communication domain is required for an autism diagnosis. (*Cedillo* Tr. at 1602A-1603.) An Asperger's diagnosis does not require communication domain impairment. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires an impairment in either this domain or the patterns of behavior discussed next. (*Id.* at 1592.)

3. Restricted, Repetitive and Stereotyped Patterns of Behavior Domain

There are four categories within this domain. They include (1) a preoccupation with an interest that is abnormal in intensity or focus, such as spinning a plate or a wheel or developing an intense fascination with a particular interest, such as dinosaurs, cartoon characters, or numbers; (2) an adherence to nonfunctional routines or rituals, such as eating only from a blue plate, sitting in the same seat, or walking the same route; (3) stereotypic or repetitive motor mannerisms, such as finger flicking, hand regard, hand flapping, or twirling; and (4) a persistent preoccupation with parts of an object, such as focusing on the wheel of a toy car and spinning it, rather than playing with the toy as a car. (*Cedillo* Tr. at 1613A-15, 1271A-72A.)

As one expert explained, this domain reflects abnormalities in the way play skills develop, as well as repetitive and rigid behavior. (*Cedillo* Tr. at 1264A.) A typical toddler may flick a light switch a few times, but the child with ASD performs the same action to excess. (*Cedillo* Tr. at 1616.) Another expert described one child who would not turn right; to make a right turn at a crossroads, he would have to make three left turns. (*King* Tr. at 3252-53.)

For a diagnosis of autism, a child must display behaviors in at least one of the categories included in this domain. (*Cedillo* Tr. at 1613A.) An Asperger's diagnosis also requires at least one behavioral impairment encompassed in this domain. (*Id.* at 1275A-76.) A PDD-NOS diagnosis requires either an impairment in this domain or an impairment in the communication domain. (*Id.* at 1592.)

C. Summary

The OAP evidence establishes that a diagnosis of ASD is based on observations of behavioral symptoms. The symptoms are categorized into three domains.

For a definitive diagnosis of autism, the child must display behavioral abnormalities in each of the domains, and must exhibit at least six of the 12 behavioral criteria in the three domains. There must be at least two behaviors encompassed in the social interaction domain, reflecting the importance of impaired social interaction in diagnosing ASD. The behavioral abnormalities must manifest before the age of three.

Thus, the absence of any specific symptom would not rule out the diagnosis, so long as the requisite numbers of impairments in each domain of functioning are present. Conversely, autism cannot be diagnosed by any single abnormal behavior, but the ultimate diagnosis is based on an accumulation of symptomatic behaviors. The existence of any one behavioral abnormality associated with autism is sufficient to trigger the running of the statute of limitations.

For a diagnosis of Asperger's disorder, the child must display behavioral abnormalities similar to those of children with autistic disorder, but need not have a language abnormality. (*Cedillo* Tr. at 1275A-76; *see also* DSM-IV-TR at 84 (requiring two impairments in social interaction and one in restricted, repetitive, and stereotyped patterns of behavior, interests, and activities for this diagnosis.))

For a PDD-NOS diagnosis, the child must display behavioral abnormalities in all three domains. However, this diagnosis is given when the impairments fall short of the criteria required for a diagnosis of autism (autistic disorder). (*Cedillo* Tr. at 1275A.)

V

LEGAL STANDARD

The Vaccine Act provides that:

> a vaccine set forth in the Vaccine Injury Table which is administered after October 1, 1988, if a vaccine-related injury occurred as a result of the administration of such vaccine, no petition may be filed for compensation under the Program for such injury after the **expiration of 36 months** after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury . . . .

§ 16(a)(2) (emphasis added). In *Cloer*, the Court of Appeals for the Federal Circuit affirmed that the statute of limitations begins to run on "the date of occurrence of the first symptom or manifestation of onset of the vaccine-related injury recognized as such by the medical profession at large." (654 F.3d 1322, 1325 (2011)). This date is dependent on when the first sign or symptom of injury appears, not when a petitioner discovers a causal relationship between the vaccine and the injury. (*Id.* at 1339.)

Under *Cloer*, "equitable tolling" of the statute of limitations may occasionally occur, but only in "extraordinary circumstances," such as when a petitioner files a defective claim within the statutory period, or is the victim of fraud or duress. (*Id.* at 1344-45 (*citing Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005)). *See also Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 96 (1990)). Equitable tolling does *not* apply simply because the statute of limitations deprives a petitioner of his or her claim. (*Cloer*, 654 F.3d at 1344.)

VI

ANALYSIS OF THIS CASE

First, I will briefly address why Petitioner's claim is untimely filed, and then I will discuss why I must reject Petitioner's request that I apply the doctrine of "equitable tolling" to Petitioner's claim.

A. This Claim Was Not Timely Filed.

As noted above, §16(a)(2) requires that a Program petition, alleging injury by a vaccination administered after October 1, 1988, must be filed within 36 months after the date of the "first symptom or manifestation of the onset" of the injury in question. In this case, Joshua began experiencing symptoms of an autism spectrum disorder ("ASD") on July 12, 1999, when he presented for a pediatric examination due to "concerns of his not talking." (Pet. Ex. 1 at 5.) As discussed earlier, speech and language delay is a recognized symptom of autism. (*See* Section IV above; *see also White v. HHS,* 04-337V, 2011 WL 6176064 (Fed. Cl. Spec. Mstr. Nov. 22, 2011) (the Special Master concluded that although not sufficient by itself to establish a diagnosis of autism, speech and language delay can constitute the first symptom or manifestation of onset of autism).)

Therefore to be timely filed, Petitioner's Vaccine Act Claim had to have been filed no later than July 12, 2002. The petition in this case, however, was not filed until March 17, 2004. Accordingly, this case was not timely filed.

B. The Circumstances of This Case Do Not Warrant Equitable Tolling.

As discussed above, although § 300aa-16(a)(2) bars this claim, Petitioner's prior counsel argued that the statute of limitations should be "equitably tolled" to allow the claim to proceed. (Response to Motion to Dismiss, Nov. 16, 2009, ECF No. 15.)

Under *Cloer*, "equitable tolling" of the statute of limitations may occasionally occur, but only in "extraordinary circumstances." (654 F.3d at 1344-45 (*citing Pace v. DiGuglielmo*, 544 U.S. 408, 418 (2005)). *See also Irwin v. Dep't of Veterans Affairs*, 498 U.S. 89, 96 (1990)). Additionally, *Cloer* specified that equitable tolling does *not* apply simply because the statute of limitations deprives a petitioner of his or her claim. (*Id.* at 1344.) Here, neither Petitioner's previous counsel nor Petitioner herself has offered any extraordinary circumstance or rationale for why this claim should be equitably tolled to allow Petitioner's claim to proceed; therefore, equitable tolling is not warranted here.

VII

CONCLUSION

I have great sympathy for the tragic disorder from which Joshua suffers. Under the applicable law, however, Petitioner has the burden to show timely filing. Petitioner has failed to do so. There is preponderant evidence that this case was not filed within "36 months after the date of the occurrence of the first symptom or manifestation of onset or of the significant aggravation of such injury" as required by the Vaccine Act, § 16(a)(2). Petitioner also has failed to demonstrate any extraordinary circumstances warranting "equitable tolling." **Therefore, this claim is dismissed as untimely filed under the Vaccine Act's statute of limitations.** §16(a)(2). **The clerk is directed to enter judgment accordingly.**

IT IS SO ORDERED.

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George L. Hastings, Jr.
Special Master